No. 14-181

IN THE

Supreme Court of the United States

ALFRED GOBEILLE, IN HIS OFFICIAL CAPACITY AS CHAIR OF THE VERMONT GREEN MOUNTAIN CARE BOARD,

Petitioner,

v.

LIBERTY MUTUAL INSURANCE COMPANY,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF OF *AMICUS CURIAE* BLUE CROSS AND BLUE SHIELD ASSOCIATION IN SUPPORT OF RESPONDENT

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INTEREST OF *AMICUS CURIAE*[1]

The Blue Cross and Blue Shield Association ("BCBSA") is the trade association that coordinates the national interests of the independent, locally operated Blue Cross and Blue Shield companies ("BCBSA Member Companies"). Together, the 36 independent, community-based and locally operated BCBSA Member Companies administer health benefit plans or provide health insurance to more than 100 million people – almost one-third of all Americans – in all 50 states, the District of Columbia, and Puerto Rico. The BCBSA Member Companies offer a variety of products supplying administrative services or insurance to all segments of the population, including private and public employer groups, small businesses, and individuals.

The BCBSA Member Companies are subject to regulations under a variety of federal and state statutes, including the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. §§ 1001 *et seq.* This case concerns whether ERISA preempts a Vermont law – Vt. Stat. Ann., tit. 18, § 9410, known as an all-payer claims database ("APCD") statute – requiring, among others, third-party administrators of self-funded ERISA plans and insurers of insured ERISA plans to report data about claims to a Vermont state agency. In their role as third-party administrator to or insurer of ERISA plans, BCBSA's Member Com-

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[1] Petitioner and Respondent have each filed letters granting blanket consent to the filing of *amicus curiae* briefs in support of either or neither party. Pursuant to Rule 37.6, the *amicus* states that no counsel for a party authored this brief in whole or in part, and no person or entity, other than the *amicus*, its members, or its counsel, made a monetary contribution to the preparation or submission of the brief.

panies are subject to Vermont's law or other states' APCD laws, insofar as such laws apply to them. They, therefore, have a substantial interest in the question whether ERISA preempts the Vermont statute and similar APCD laws existing in other states.

SUMMARY OF ARGUMENT

I. This case offers the opportunity for a necessary update of some of the governing ERISA express preemption principles emanating from *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995). The use of a presumption against ERISA express preemption, as *Travelers* invokes, is inharmonious with the Court's developing jurisprudence on express preemption provisions generally and with other ERISA precedents that have warned against the use of presumptions when construing ERISA statutory terms. Additionally, the *Travelers* preemption regime devolves, in practice, to a standard close to ordinary conflict preemption, which unduly restricts a preemption clause that Congress anticipated, at the time of enactment, would be expansive. And *Travelers* and its progeny have not brought greater predictability to the ERISA preemption area, with lower courts (as the majority and dissent did here) continuing to diverge on whether similar state laws are preempted under ERISA's preemption clause, 29 U.S.C. § 1144(a).

In order to bring better order to the area, the Court should discard a presumption against ERISA preemption, leaving § 1144(a) to be applied without artificially tipping the balance in favor of the states and against federal interests. Another important improvement the Court can make is to reinvigorate

the "reference to" component of ERISA express preemption, whereby state laws that refer to ERISA plans are found to "relate to any employee benefit plan" (29 U.S.C. § 1144(a)) and thus be preempted. The Court has taken much power from the "reference to" benchmark by indicating it applies where a state law applies exclusively to ERISA plans. The Court should return to the rubric adopted in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), by finding ERISA to preempt a state law that facially includes ERISA plans or their essential actors among its regulatory objects. The test is easily applied and truer to ERISA's text. Vermont's APCD law would succumb under that "reference to" test.

II. Even without any adjustment to the current ERISA express preemption framework, the Vermont law is preempted. Under *Travelers* and its progeny, a state law "relates to" (in the sense it has a "connection with") ERISA plans and is therefore preempted when it interferes with ERISA's objectives. Because one of ERISA's main goals is to ensure uniform, exclusively federal reporting by ERISA plans, and because Vermont's law upsets that goal, the Vermont statute is preempted under § 1144(a). In further support of Respondent, the *amicus* emphasizes two points key to the preemption analysis. First, ERISA's reporting obligations – and thus a subject on which Congress sought uniform standards – include reporting on *medical claims data*. The Affordable Care Act expressly incorporated into ERISA transparency requirements contained in the Public Health Service Act, and those requirements are intricate and cover the same ground as Vermont's APCD law. Second, the compliance burdens created by Vermont's law and other states' similar laws are immense, especially for multi-state ERISA plans.

ARGUMENT

I. THE COURT SHOULD REVISE ITS ERISA EXPRESS PREEMPTION JURISPRUDENCE

A. *The Preemption Standards Articulated in Travelers and Its Progeny Are in Need of Updating*

Twenty years have passed since *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) ["*Travelers*"], a decision that "marked something of a pivot in ERISA preemption." Pet. App. 18. While intended to adjust an existing body of decisions that the Court believed did "not give us much help drawing the line" for ERISA preemption (*Travelers*, 514 U.S. at 655), *Travelers* itself is now in need of repair. One threshold rule it set forth for preemption – namely, a presumption against express preemption – is now in tension with the Court's since-developed case law in other preemption contexts and even in other ERISA settings. Moreover, the post-*Travelers* regime aligns too closely to ordinary "conflict" preemption. And *Travelers* and its progeny have not lessened unpredictability in this area of the law.

1. ERISA's preemption section states that "the provisions of [ERISA] . . . shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b)." 29 U.S.C. § 1144(a). ERISA §§ 4(a) and 4(b), in turn, extend ERISA's coverage to any employee benefit plan established or maintained by a private employer or employee organization (such as a union) and exempt plans operated by government employers and churches (along with a few others). *See id.* § 1003(a)-(b). Of course, the key words of the preemption sec-

tion, and the ones that have spawned so much discussion in the case law, are those bringing within the section's compass state laws that "relate to any employee benefit plan."

Faced once again, after many prior attempts, with the challenge of interpreting those words, the Court in *Travelers* announced – for the first time – that there would be a presumption against preemption when applying ERISA's express preemption section. "[T]he starting presumption [is] that Congress does not intend to supplant state law." *Travelers*, 514 U.S. at 654. Thus, in ERISA cases, including in *Travelers* itself, "where federal law is said to bar state action in fields of traditional state regulation," the courts must "work[] on the 'assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress.'" *Id.* at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

Next, the Court registered "frustrat[ion]" with its earlier attempts to construe § 1144(a). *Travelers*, 514 U.S. at 656. "Relate to" is a phrase that, on its face, does not "do much limiting." *Id.* at 655. From early on, attempting to give content to the text, the Court had explained that "[a] law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines*, 463 U.S. 85, 96-97 (1983). But the "connection with" language, proved to be scarcely "more help than . . . 'relate to.'" *Travelers*, 514 U.S. at 656. "For the same reasons that infinite relations cannot be the measure of preemption, neither can infinite connections." *Id.* And the "reference to" prong of the standard often did not

aid matters because the Court, in *Travelers* and then subsequent cases, said it applies to the narrow and infrequent situation "[w]here a State's law acts immediately and exclusively upon ERISA plans, . . . or where the existence of ERISA plans is essential to the law's operation." *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 325 (1997) ["*Dillingham*"]; *accord Travelers*, 514 U.S. at 656.

Accordingly, to go "beyond the unhelpful text," at least on the "connection with" side of things, the Court emphasized that ERISA preemption decisions should be tied to the statute's underlying purposes. The courts must "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." *Travelers*, 514 U.S. at 656. In *Travelers*, the Court also identified the underlying purpose most relevant to preemption inquiries: with the preemption section, "Congress intended 'to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . . , [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.'" *Id.* at 656-57 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)) (alterations in original).

The Court in *Travelers* also surveyed its past decisions and noted the types of state laws that would fail under the revamped preemption regime. In so doing, the Court provided the lower courts with a sort of shorthand checklist of the types of state laws

that would conflict with ERISA's goal of uniform national regulation and not survive merely on the presumption against preemption. Referring to its prior precedents, the Court said: "In each of these cases, ERISA pre-empted state laws that mandated employee benefit structures or their administration. Elsewhere, we have held that state laws providing alternative enforcement mechanisms also relate to ERISA plans, triggering pre-emption." *Id.* at 658 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *FMC Corp. v. Holliday*, 498 U.S. 52 (1990); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990)).

2. *Travelers* – especially its presumption against preemption – has become out of step with the Court's more general preemption jurisprudence. In recent cases, several Justices have criticized the use of a presumption against preemption in express preemption contexts. As Justice Scalia has stated, joined by three other Justices:

> I remain convinced that "[t]he proper rule of construction for express pre-emption provisions is . . the one that is customary for statutory provisions in general: Their language should be given its ordinary meaning." *Cipollone v. Liggett Group, Inc.*, 505 U. S. 504, 548, 112 S. Ct. 2608, 120 L. Ed. 2d 407 (1992) (Scalia, J., concurring in judgment in part and dissenting in part). The contrary notion – that express pre-emption provisions must be construed narrowly – was "extraordinary and unprecedented" when this Court announced it two decades ago, *id.*, at 544, 112 S. Ct. 2608, 120 L. Ed. 2d 407, and since then our reliance

> on it has been sporadic at best, *see Altria Group, Inc. v. Good*, 555 U. S. 70, 99-103, 129 S. Ct. 538, 172 L. Ed. 2d 398 (2008) (Thomas, J., dissenting).

CTS Corp. v. Waldburger, 134 S. Ct. 2175, 2189 (2014) (Scalia, J., concurring, and joined by Roberts, C.J., and Thomas and Alito, J.J.). Justice Kennedy has added that the notion of a presumption against preemption from prior express preemption case law is better thought of "not as a presumption but as a cautionary principle to ensure that pre-emption does not go beyond the strict requirements of the statutory command." *Ariz. v. Inter Tribal Council of Ariz., Inc.*, 133 S. Ct. 2247, 2261 (2013) (Kennedy, J., concurring).

Evidencing the point that application of a presumption against express preemption has been sporadic, the Court has regularly, even in the time roughly contemporaneous to *Travelers* and since then, decided express preemption cases without mentioning any such presumption. In this competing body of case law, the Court has treated the question of express preemption as "one of statutory intent, and [the Court] begin[s] with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose." *Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383 (1992) (internal quotation marks and citation omitted); *accord Sprietsma v. Mercury Marine*, 537 U.S. 51, 62-63 (2002); *see generally Northwest, Inc. v. Ginsberg*, 134 S. Ct. 1422, 1429-33 (2014) (finding express preemption with no reference to any presumption against preemption).

Even if a presumption against preemption did fit other statutory regimes with express preemption

provisions, the Court should eschew it for ERISA. The Court – also in the time since *Travelers* – has clarified that judge-made presumptions are especially unsuited for a comprehensive, highly-reticulated statute like ERISA. For instance, in *Fifth Third Bancorp v. Dudenhoeffer*, 134 S. Ct. 2459, 2463 (2014), the Court considered "whether, when an [employee stock ownership plan ('ESOP')] fiduciary's decision to buy or hold the employer's stock is challenged in court, the fiduciary is entitled to a defense-friendly standard that the lower courts have called a 'presumption of prudence.'" The Court rejected such a presumption upon reviewing the statutory provisions concerning fiduciary conduct, finding they "make[] no reference to a special 'presumption' in favor of ESOP fiduciaries." *Id.* at 2467. Similarly, in *M&G Polymers USA, LLC v. Tackett*, 135 S. Ct. 926, 935 (2015), the Court rejected a "presumption" (previously applied by the Sixth Circuit) favoring the vesting of retiree health benefits in collective-bargaining situations. Because ERISA's terms give employers "large leeway to design disability and other welfare plans as they see fit," the ERISA plans "should be enforced as written," subject only to "ordinary principles of contract law." *Id.* at 933 (internal quotation marks omitted); *see also Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003) (rejecting presumption favoring views of treating physician in the processing of health-benefit claims, because "[n]othing in the Act itself . . . suggests that plan administrators must accord special deference to the opinions of treating physicians").

Whereas in these other ERISA situations the Court was unwilling to add presumptions unmentioned in the text of the specific ERISA provisions at issue, the Court in *Travelers* did the opposite: it cre-

ated a presumption on preemption nowhere referenced in ERISA's express preemption clause. Consistent with the Court's more recent rejection of interpretive devices unmoored in ERISA's actual terms, ERISA's express preemption regime too should be "shorn of presumptions." *M&G Polymers*, 135 S. Ct. at 927 (Ginsburg, J., concurring).

Not only is a presumption against ERISA express preemption in tension with the Court's other preemption and ERISA case law, it was, respectfully, from the start contrary to Congress's original intent with regard to § 1144(a). As Respondent's brief ably demonstrates in its thorough review of ERISA's legislative history (*see* Resp. Br. 17-23), Congress did not in 1974 have in mind the sort of narrow preemption when it comes to ERISA that a presumption against preemption implies. To the contrary, the Court has characterized ERISA's preemption section on numerous occasions as "clearly expansive," having "a broad scope," having "an expansive sweep," "conspicuous for its breadth," "deliberately expansive," and "broadly worded." *Dillingham*, 519 U.S. at 324 (referencing Court's statements in earlier precedents) (internal quotation marks and citations omitted); *see also Egelhoff*, 532 U.S. at 146. When a provision in a statute is characterized by Congress and this Court alike as the statute's "'crowning achievement,'" as ERISA's preemption clause has been described, it makes little sense *to begin* analysis of whether the provision operates in a particular situation with an approach that all doubts shall be resolved against the provision's application. *Shaw*, 463 U.S. at 99 (quoting 120 Cong. Rec. 29,197 (1974) (statement of Rep. Dent)).

3. *Travelers*'s instruction to focus the express preemption inquiry on ERISA's purposes (at least when applying the "connection with" language) likewise artificially constricts the power of § 1144(a). Again, under *Travelers*, courts look to "'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' as well as to the nature of the effect of the state law on ERISA plans." *Dillingham*, 519 U.S. at 325. True enough, a court should refrain from woodenly applying a preemption clause, without regard to its purposes. But *Travelers*'s focus on the statutory objectives has had a tendency to conflate ERISA express preemption with ordinary conflict preemption. Since at least 1941, the Court has enforced a conflict preemption standard whereby a state law is supplanted by federal law if the state enactment "stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Hines v. Davidowitz*, 312 U.S. 52, 67 (1941); *accord Geier v. Am. Honda Motor Co.*, 529 U.S. 861, 881-82 (2000). In language reminiscent of *Hines*, the Court in *Travelers* found a New York law exacting surcharges on certain types of commercial insurance to escape preemption, because "cost uniformity was almost certainly not an object of [ERISA] pre-emption." 514 U.S. at 662.

The problem with transforming ERISA express preemption simply into an examination of whether the application of state law would upset Congress's ERISA objectives is that it makes § 1144(a) superfluous. That is, the *Hines* conflict preemption standard existed prior to ERISA and applies in any federal statutory context, irrespective of whether it has an express preemption provision. It therefore would apply in the ERISA context, even absent Congress's

enactment of § 1144(a). Yet, Congress still enacted ERISA's express preemption clause, showing it wanted something more. While relegating a statutory provision to the category of surplussage is never favored, it should truly be anathema for ERISA's express preemption provision, where we know Congress intended the section to be key to the legislation and even revolutionary for its time. *See Franchise Tax Bd. v. Constr. Laborers Vacation Trust*, 263 U.S. 1, 24 n.26 (1983) (describing § 1144(a) as a "virtually unique pre-emption provision").

Adding further to the funneling of most ERISA preemption cases into a conflict preemption framework was the Court's simultaneous diminishment of the "reference to" standard for determining when a law "relates to" employee benefit plans. Earlier, the "reference to" prong had a greater scope (*see infra* p. 16); however, *Travelers* and *Dillingham* appeared to limit that part of the test to state laws that name ERISA plans as their "exclusive" subject. *See Dillingham*, 519 U.S. at 325. It is a rare instance where a state passes a law that seeks to regulate ERISA plans, and just them, given the long history of substantial preemption. Consequently, by constricting the reach of the "reference to" test, the Court left nearly all express preemption issues to be determined under the more conflict-preemption-oriented approach associated with the "connection with" strand.

4. *Travelers* also has not, as might have been hoped, ushered in an era of predictable, consistent lower court decisions on ERISA preemption questions. On significant issues, the lower courts – all espousing to apply dutifully *Travelers*'s teachings – have reached opposite conclusions on similar state

laws. *Compare Pharm. Care Mgmt. Ass'n v. D.C.*, 613 F.3d 179 (D.C. Cir. 2010) (finding that ERISA preempts District of Columbia law regulating contracts with pharmacy benefit managers) *with Pharm. Care Mgmt. Ass'n v. Rowe*, 429 F.3d 294 (1st Cir. 2005) (rejecting preemption for similar Maine law); *compare Retail Indus. Leaders Ass'n v. Fielder*, 475 F.3d 180, 183 (4th Cir. 2007) (finding that ERISA preempts Maryland law requiring specific level of employer expenditures for employee health benefits) *with Golden Gate Rest. Ass'n v. City & Cnty. of San Francisco*, 546 F.3d 639 (9th Cir. 2014) (finding similar local California ordinance not to be preempted); *compare America's Health Ins. Plans v. Hudgens*, 742 F.3d 1319 (11th Cir. 2014) (holding that ERISA preempts Georgia's claims prompt-payment law as applied to self-funded ERISA plans) *with Aetna Life Ins. Co. v. Methodist Hosps. of Dallas*, No. 3:14-cv-347-M, 2015 U.S. Dist. LEXIS 26455 (N.D. Tex. Mar. 4, 2015) (finding no preemption for similar Texas law), *appeal pend'g*, No. 15-10210 (5th Cir. filed Mar. 17, 2015).

One reason that *Travelers* results in unpredictability is that purposes-oriented preemption (as under *Hines*) can sometimes turn into a "'freewheeling judicial inquiry into whether a state statute is in tension with federal objectives,'" rather than "an inquiry into whether the ordinary meanings of state and federal law conflict." *Bates v. Dow Agrosciences L.L.C.*, 544 U.S. 431, 459 (2005) (Thomas, J., concurring in part and dissenting in part) (quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 111 (1992) (Kennedy, J., concurring)); *accord Geier*, 529 U.S. at 911 (Stevens., J., dissenting) (criticizing *Hines* preemption as not "a matter of precise statutory construction," but "an exercise in free-form judicial policy-

making") (internal quotation marks, citation, and alteration omitted).

Another reason that *Travelers* has not brought order to the ERISA preemption arena is that it failed to solve the "difficulty of defining [the express preemption section's] key term." *Travelers*, 514 U.S. at 656. *Travelers* exchanged defining terms such as "relates to," has "connection with," or makes "reference to" employee benefit plans with inquiries into whether a state law concerns "employee benefit plan structures" or "administration," with state laws falling within the scope of the latter terms being on the *Travelers* shorthand list of suspect state measures. *Id.* at 658. "Structures" and "administration" are not precise terms, as the majority and dissenting opinions in Second Circuit in this case illustrate. *See* Pet. App. 29 n.13 ("The dissent draws a 'distinction between general administration and administration of plans, claims, and benefits . . . .'") (citation omitted); *see also Golden Gate Rest. Ass'n*, 546 F.3d at 657 (finding that impermissible requirements regarding administration must mean the "administrative [or] financial burden of complying with conflicting directives relating to benefits law") (internal quotation marks and citation omitted).

B. *The Court Should Revise Its § 1144(a) Standards to Eliminate the Presumption Against Preemption and to Revive a More Potent "Reference to" Analysis*

Travelers was not the cure, and the Court should use this case to bring greater predictability and order to the ERISA express preemption area. It first should discard the presumption against preemption, consistent with the Court's developing general jurisprudence critical of such a presumption in express

preemption contexts and with its ERISA case law rejecting judge-made presumptions for construing ERISA statutory terms. Instead, the Court should "interpret[] the statute without reference to the presumption or any perceived need to impose a narrow construction on the provision in order to protect the police power of the States." *Altria Group, Inc. v. Good*, 555 U.S. 70, 101 (2008) (Thomas, J., dissenting, and joined by Roberts, C.J., and Scalia and Alito, J.J.). Where "an express pre-emption clause" exists, the courts' "task of statutory construction must in the first instance focus on the plain wording of the [express preemption] clause, which necessarily contains the best evidence of Congress' pre-emptive intent"). *Sprietsma v. Mercury Marine*, 537 U.S. 51, 62-63 (2002) (internal quotation marks and citation omitted).

Of course, § 1144(a)'s text has been a source of frustration for the Court, and it therefore would not do much good to re-focus the statutory analysis away from a presumption and to the text, unless some greater clarity can now be ascribed to "relate to." To that end, one substantial improvement the Court could make would be to resuscitate the "reference to" prong of the "relate to" test. In *Travelers* and *Dillingham*, the Court appeared to relegate (or at least the lower courts have assumed as much) a "reference to" finding principally to state laws that target exclusively ERISA plans, an uncommon occurrence. *See supra* p. 6. But that was not always the case. In *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), the Court found a Pennsylvania anti-subrogation law preempted under the following reasoning:

> Pennsylvania's antisubrogation law has a "reference" to benefit plans governed by ERISA.

> The statute states that "in actions arising out of the maintenance or use of a motor vehicle, there shall be no right of subrogation or reimbursement from a claimant's tort recovery with respect to . . . benefits paid or payable under section 1719." 75 Pa. Cons. Stat. § 1720 (1987). Section 1719 refers to "any program, group contract or other arrangement for payment of benefits." These terms "include, *but [are] not limited to*, benefits payable by a hospital plan corporation or a professional health service corporation." § 1719 (emphasis added).

FMC Corp., 498 U.S. at 59 (emphasis and alterations in original).

In *FMC Corp.*, then, the Court found that a state law made "reference to" ERISA plans because it addressed benefits and contracts for benefits and contained language extending its reach to benefits payable from a private employee benefit plan (*i.e.*, by not limiting itself solely to non-ERISA employee benefit plan situations). *Cf. Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 (1987) (finding that contract and tort state law causes of action "undoubtedly meet the criteria for pre-emption under § 514(a)" because "each [was] based on alleged improper processing of a claim for benefits *under an employee benefit plan*") (emphasis added). The Pennsylvania law did not work exclusively on ERISA plans, but operated on an enumerated field that encompassed ERISA plans and did not seek to exclude them.[2]

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[2] *FMC Corp.*'s test that a state law references ERISA plans when it includes ERISA plans *among* its objects is more consistent with § 1144(a)'s text than is the *Travelers-Dillingham* notion that the state law must reference *exclusively* ERISA plans. After all, "reference to" is a construction of "relate to" in

Some ease and predictability could be added to the ERISA express preemption area, were the Court to return to a test whereby a state law makes "reference to" ERISA plans if it overtly mentions employee benefit plans, employee benefits, or the entities inextricably tied to employee benefit plans – such as third-party administrators or pharmacy benefit managers – as among its objects, even if they are not the sole objects of the state legislation. The test would be easy to apply, because courts could refer to the face of the state measure to determine if it names employee benefit plans or the actors associated with employee benefit plans. There would be predictability, since there would be facial analysis of statutory text, not the less precise gleaning of the purposes of ERISA and weighing of whether the state law frustrates or otherwise too negatively impacts those purposes.[3]

Under a strengthened "reference to" standard, Vermont's APCD law would be preempted – easily.

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the statute, and the statute does not provide that state laws are preempted if they "relate *only or solely* to any employee benefit plan" but simply if they "relate to any employee benefit plan."

[3] Laws of general application that regulate businesses or the public generally, and thus for that lone reason include ERISA plans among their regulated entities, would not be preempted under the invigorated "reference to" test. It is laws that overtly take aim at employee benefit plans or those who administer them that would be superseded. Hence, a general garnishment statute would not be preempted, but a state law that sets forth procedures specifically for the garnishment of fringe benefits would be. *See generally Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 831-32 (1988). Similarly, a general sales tax would not be preempted, but a state tax on the processing of benefit claims would be. *But see Self-Ins. Inst. of Am., Inc. v. Snyder*, 761 F.3d 631 (6th Cir. 2014), *pet. for cert. pend'g*, No. 14-741 (filed Dec. 18, 2014).

In brief, it mentions among the objects it brings under its control private-employer employee benefit plans. The implementing regulations for Vermont's statute make this obvious. In the regulations, Vermont extends the reporting law to "any *administrator* of an insured, self-insured, or publicly funded *health care benefit plan* offered by public and *private* entities." Vt. Reg. H-2008-01, § 3(X) (Pet. App. 112-13) (emphasis added). By extending its operation to those who administer employee benefit plans governed by ERISA (whether they are insured or self-funded), the state law refers to ERISA plans. In sum, the preemption analysis under § 1144(a) could begin and end with the text of that one Vermont regulation.

Finally, even with an updated "reference to" test, there would remain for state laws surviving that test the hurdle of avoiding a "connection to" ERISA plans, with the attendant complications of making preemption determinations under the *Travelers* approach. But at least the "reference to" test would mean that, in many instances, a simpler methodology focused on the text of the state law, as well as the text of § 1144(a) (*i.e.*, with "relate to" meaning "reference to"), would govern the preemption outcome. Moreover, the elimination of the presumption against preemption even for "connection with" analysis would remove the "tip[ping of] the scales in favor of the States and against the Federal Government," in a situation where Congress emphasized the primacy of federal interests by enacting a broad preemption provision. *Bates v. Dow Agrosciences L.L.C.*, 544 U.S. 431, 457 (2005) (Thomas, J., concurring in part and dissenting in part, and joined by Scalia, J.).

II. THE VERMONT LAW IS EXPRESSLY PREEMPTED UNDER EXISTING § 1144(a) STANDARDS

A. *Under Current Law, ERISA Expressly Preempts the Vermont Law Due to Its Interference with Congress's Desire for Uniformity in Reporting*

Even without any revision to the regime ushered in by *Travelers*, Vermont's APCD law cannot survive ERISA express preemption. After *Travelers*, a state statute that interferes with ERISA's objectives "relates to" – in particular, has a "connection with" – ERISA plans under § 1144(a) and, therefore, is preempted. *See Travelers*, 514 U.S. at 653; *see also Egelhoff v. Egelhoff*, 532 U.S. 141, 147 (2001) ; *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813-14 (1997); *Dillingham*, 519 U.S. at 325. One of ERISA's oft-repeated chief aims was to ensure uniform, and thus exclusively federal, regulation on core subjects covered by ERISA, and that includes reporting. *See Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137 (1990) (ERISA "sets various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility"). The underpinning for uniformity is straightforward: "Requiring ERISA administrators to master the relevant laws of 50 States" – whether on reporting or other areas addressed in ERISA – "would undermine the congressional goal of 'minimizing the administrative and financial burdens' on plan administrators – burdens ultimately borne by the beneficiaries." *Egelhoff*, 532 U.S. at 149-50 (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990)).

Indeed, the situation prior to ERISA's enactment, where states had control over reporting with respect

to employee benefit plans proved unworkable. ERISA's reporting and disclosure requirements superseded the Welfare and Pension Plans Disclosure Act ("WPPDA"), 72 Stat. 997 (1958). The WPPDA did not authorize the Labor Department to prescribe the "'form and detail'" of reporting but permitted states to regulate such reporting, which resulted in "administrative chaos." Administration Recommendations to the House and Senate Conferees on H.R. 2 to Provide for Pension Reform, at 88 (Apr. 1974), *reprinted in* Staff of S. Subcomm. on Labor of Comm. on Labor & Pub. Welfare, 94th Cong., Vol. III, Legislative History of [ERISA] of 1974, at 5131 (Comm. Print Apr. 1976) [hereinafter "Comm. Print"]. With ERISA, Congress repealed the WPPDA and replaced it with simple, uniform reporting requirements "consolidate[d] . . . into a single report." *Id.* at 83, Comm. Print at 5126. It did so not solely as a matter of administrative convenience for the federal government; Congress believed it was "essential" to "minimize the burdens placed on plan administrators by . . numerous reporting requirements." *Id.*; *see generally Malone v. White Motor Corp.*, 435 U.S. 497, 505, 512 (1978).

Thus, because a state law conflicting with ERISA's objectives fails under § 1144(a), and one of ERISA objectives, in turn, is uniformity in requirements for reporting by ERISA plans, ERISA would expressly preempt Vermont's law if the law frustrates the attainment of nationally uniform ERISA-plan reporting standards. Respondent's brief (as with the Second Circuit's decision) more thoroughly illustrates that Congress intended reporting on ERISA plans to be a core ERISA subject matter, and likewise intended uniformity in the subject matter.

Resp. Br. 17-24. And it also shows how the Vermont law breaches those standards. *Id.* at 24-47.

The *amicus* wishes (in the sections below) to expand on two points key to the preemption analysis, on which the *amicus* – as an association of entities that administer or insure health benefits for nearly one-third of all Americans – is uniquely positioned to contribute: (1) the extent to which reporting of specifically *medical claims data* is a core matter within ERISA's confines; and (2) the heavy burdens placed on ERISA administrators and insurers by APCD laws, particularly disparate APCD state laws applicable to multi-state ERISA plans. Both points enhance further the case for express ERISA preemption under currently governing standards.

B. *ERISA Requires Detailed Reporting Concerning Medical Claims Data and Similar Information, and the Vermont Law Undermines the Exclusivity of Those Requirements*

1. ERISA's reporting obligations extend to medical claims information for self-funded and insured ERISA plans. Most recently, with the passage of the Patient Protection and Affordable Care Act ("ACA") and subsequent related legislation, Congress instructed additional reporting requirements for health plans covered by ERISA. Through portions of the Public Health Service Act ("PHSA"), 42 U.S.C. §§ 300gg *et seq.*, which are *expressly incorporated into ERISA*, group health plans (including self-insured plans) and health insurance issuers that insure group health plans within ERISA's scope are required to report information concerning the cost and quality of health care. *See* FAQs About Affordable Care Act Implementation (Part XV) (Apr. 29, 2013) ["ACA FAQs"], http://www.dol.gov/ebsa/faqs/faq-aca

15.html. ERISA's incorporation provision states: "the provisions of part A of Title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, and health insurance issuers providing health insurance coverage in connection with group health plans, *as if included in this subpart.*" 29 U.S.C. § 1185d(a)(1) (emphasis added).

Specifically, under what are known as the PHSA's "transparency" in coverage provisions – again, as incorporated into ERISA – group health plans and health insurance issuers must submit information to the Departments of Health and Human Services ("HHS"), Labor, and Treasury (collectively, the "Departments") and the relevant state insurance commissioner about:

i) Claims payment policies and practices

ii) Periodic financial disclosures

iii) Data on enrollment

iv) Data on disenrollment

v) Data on denied claims

vi) Data on rating practices

vii) Cost-sharing and payment for out-of-network coverage

viii) Enrollee and participant rights

ix) Other information as determined appropriate by the [Departments].

42 U.S.C. §§ 18031(e)(3)(A), 300gg-15a; ACA FAQs at Q3, http://www.dol.gov/ebsa/faqs/faq-aca15.html.

The transparency provisions took effect in 2010, but the Departments have provided notice that they will not require compliance with the provisions until a later date to be set by them, after notice-and-

comment rulemaking regarding the provisions' requirements.[4] The Secretary of Labor, in turn, is tasked with "updat[ing] and harmoniz[ing] the Secretary's rules concerning the accurate and timely disclosure to participants by group health plans of plan disclosure, plan terms and conditions, and periodic financial disclosure with the standards established" by the Departments under the transparency provisions. 42 U.S.C. § 18031(e)(3)(D); *see also* ACA FAQs at Q4, http://www.dol.gov/ebsa/faqs/faq-aca15.html ("the Departments will coordinate regulatory guidance on the transparency in coverage standards").[5]

Also under the ACA-related PHSA provisions incorporated into ERISA, the Departments, "in consultation with experts in health care quality and stakeholders, shall develop reporting requirements for use by a group health plan, and a health insurance issuer offering group or individual health insurance coverage, with respect to plan or coverage benefits and

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[4] *See* ACA FAQs at Q4, http://www.dol. gov/ebsa/faqs/faq-aca15.html; *see also* HHS, Agency Information Collection Activities: Proposed Collection, Comment Request on Transparency Reporting Provisions, 80 Fed. Reg. 48320 (Aug. 12, 2015); DOL, FAQs about Affordable Care Act Implementation (Part XXVIII) (Aug. 11, 2015), http://www.dol.gov/ebsa/faqs/faq-aca28.html.

[5] The United States notes that the Department of Labor is "currently considering a rulemaking to require health plans to report more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings." U.S. *Amicus* Br. 3-4. Just because rules have not yet been finalized does not mean the states can act in the meantime. *See Guss v. Utah Labor Relations Bd.*, 353 U.S. 1, 10-11 (1957) (holding that the States are not free to regulate conduct in areas that Congress has decided require national uniformity through federal preemption, even when "federal power has been delegated but lies dormant and unexercised") (internal quotation marks and citation omitted).

health care provider reimbursement structures." 42 U.S.C. § 3300gg-17(a)(1); *see* 29 U.S.C. § 1185d(a). Additional reporting is required (again as part of the PHSA provisions incorporated into ERISA) for insurers of ERISA plans, which must submit reports to HHS concerning the percentage of premium revenue that they spend on claims for group health plans they insure. 42 U.S.C. § 300gg-18.

These recent additions to ERISA's reporting requirements fortify that reporting – indeed, detailed reporting about claims, eligibility, and other aspects of welfare benefit plan experience – is and remains a core ERISA concern. And to boot, there are additional preemption terms that cover these new reporting requirements and that re-confirm the preemptive force under § 1144(a) of the requirements. In 29 U.S.C. § 1191(a), Congress provided:

> (1) Subject to paragraph (2) . . . this part shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in connection with group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of this part.
>
> (2) Nothing in this part shall be construed to affect or modify *the provisions of section 1144 of this title* with respect to group health plans.

29 U.S.C. § 1191(a)(1)-(2) (emphasis added). Hence, § 1191 instructs – in subsection (a)(2) – that substantive provisions in this part of ERISA, including the transparency requirements added from the PHSA

and ACA, enjoy the usual ERISA preemptive power vested through § 1144. Subsection (a)(1) additionally instructs that Congress's decision to regulate in the insurance areas covered in this part of ERISA should not be read as an effort to upend the usual protection for state law afforded by the insurance savings clause, 29 U.S.C. § 1144(b)(2)(A), unless the state law establishes standards for health insurers that prevent the application of – *i.e.*, conflict with – this part of ERISA.[6]

2. The Vermont law is preempted under § 1144(a) because it undermines ERISA's aim for uniform, and thus exclusively federal, reporting. ERISA's reporting obligations include – particularly as a result of ERISA's incorporation of the PHSA transparency standards via the ACA – reporting on medical claims and other welfare plan data. Concurrently with ERISA reporting requirements, the Vermont law establishes a database to determine health care resources, needs, policy, quality, and cost. *See* Vt. Stat. Ann. tit. 18, § 9410. Under the state law, ERISA plans and their insurers must report a broad range of data, including claims and enrollment information and "any other information relating to

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[6] State law requirements, such as Vermont's, requiring reporting on claims and other medical data would not constitute saved state insurance regulations, since they do not "substantially affect the risk pooling arrangement between the insurer and the insured." *Ky. Ass'n of Health Plans v. Miller*, 538 U.S. 329, 342 (2003). In reality, APCD laws have nothing to do with risk-pooling at all, just reporting, and therefore are preempted under § 1144(a) both for self-funded and insured ERISA plans. But § 1191(a)(1) still plays an important role, because there are other provisions in this part of ERISA besides transparency, such as benefit mandates, that do implicate the insurance savings clause. *See, e.g.*, 29 U.S.C. §§ 1182-83 (mandating certain mental health and mastectomy coverage).

health care costs, prices, quality, utilization, or resources required by the Board," in an electronic format. *Id.* § 9410(c)(3), (h). Viewed in light of the PHSA transparency requirements codified in ERISA, Vermont's reporting scheme – as noted in the chart below – attempts to foist a detailed, burdensome layer of reporting on ERISA plans that is sometimes overlapping with, and sometimes additional to and conflicting with, the federal system (with rough counterparts side by side below):

Information Required by ERISA, 29 U.S.C. § 1185a, by incorporating 42 U.S.C. §§ 300gg-15a, 18031(e)(3)(A)	***Information Required by Vt. Stat. Ann., tit. 18, § 9410 and Reg. H-2008-01, Vt. Code R. ("Reg. H")***
Claims payment policies and practices (42 U.S.C. § 18031(e)(3)(A)(i))	Health insurance claims and enrollment information (§ 9410(c)(1); Reg. H, §§ 4, 5)
Periodic financial disclosures (42 U.S.C. § 18031(e)(3)(A)(ii))	(No counterpart)
(No counterpart)	Information relating to hospitals (§ 9410(c)(2))
Data on enrollment (42 U.S.C. § 18031(e)(A)(iii))	Member eligibility data relating to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities to both Vermont residents and non-residents

	(§ 9410(h)(1)(A); Reg. H, § 5(A)(9))
Data on disenrollment (42 U.S.C. § 18031(e)(3)(A)(iv))	(No counterpart)
Data on denied claims (42 U.S.C. § 18031(e)(3)(A)(v))	Data on paid claims (§ 9410(h)(1)(B); Reg. H, § 4(A), (D), 5(A))
Data on rating practices (42 U.S.C. § 18031(e)(3)(A)(vi))	(No counterpart)
(No counterpart)	Subscriber information necessary to determine third-party liability for benefits provided (§ 9410(h)(1)(C))
Cost-sharing and payment for out-of-network coverage (42 U.S.C. § 18031(e)(3)(A)(vii))	Co-insurance and co-payment information (Reg. H, § 4(A)(6))
(No counterpart)	Coordination of benefit claim information (Reg. H, § 4(A)(7))
Enrollee and participant rights (42 U.S.C. § 18031(e)(3)(A)(viii))	(No counterpart)
(No counterpart)	Pharmacy claim information (Reg. H, § 5(A)(14)-(15))
Other information as determined appropriate by the Departments (42 U.S.C.	Other information relating to health care costs, prices, quality, utilization, or resources

§ 18031(e)(3)(A)(ix))	required by the Board (§ 9410(c)(3))
Timing and manner of reporting to be developed through coordination among Departments (45 C.F.R. § 156.220(b); ACA FAQs at Q4)	Information for ERISA plans with 2000 or more participants must be submitted *monthly*; 500 to 1999 participants *quarterly*; and 200 to 499 participants *annually* (Reg. H, § 6(I))

As the chart evinces, Vermont's reporting law treads on the area covered by ERISA's reporting requirements, not only duplicating federal requirements but also supplementing and conflicting with them by requiring significant additional information and imposing a rigid reporting schedule not required under federal law. Yet, ERISA was designed "to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" *Travelers*, 514 U.S. at 656 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). A nationally "uniform administrative scheme" on reporting cannot possibly exist if Vermont's law, along with similar laws existing in other states, add to ERISA's national reporting requirements. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987). On the basis of this interference with ERISA's objective for uniformity in the core area of reporting for employee benefit plans, including reporting concerning medical claims data, the Vermont statute is preempted under § 1144(a).

C. *The Heavy Administrative Burdens Created by the Vermont Law, Particularly for Multi-State ERISA Plans, Highlight the Need for Preemption*

Preemption here is necessarily enhanced, as the Second Circuit held, by the significant burden of complying with differing state APCD laws. *See Egelhoff v. Egelhoff*, 532 U.S. 141, 151 (2001) (buttressing preemption holding with finding that "the burden [of compliance with the state law] . . . is hardly trivial"). Petitioner casually dismisses the Court of Appeals's finding that the burden created by compliance with divergent laws of this genre is "intolerable." Pet. App. 25. In this regard, Petitioner assumes that those administering ERISA plans, including the BCBSA Member Companies as third-party administrators to self-funded plans and insurers of insured ERISA plans, already collect the data necessary to meet each state's reporting requirements, *see* Pet. Br. 23, 52-55, and that it is as simple as pushing a few buttons to transmit the required data to any number of states. *Id.* at 55 ("Reams of information may be transmitted with a few key strokes."). In our experience, however, compliance with state reporting requirements like Vermont's can be just as time-consuming, frustrating, and resource-intensive as the Court of Appeals determined.

Typically, a substantial majority of a BCBSA Member Company's business is private-employer based and, therefore, subject to ERISA. In administering that significant portion of its business, then, the BCBSA Member Company – if APCD laws were not preempted by ERISA – must comply not only with federal reporting obligations under ERISA to which the ERISA plan is subject, but also potentially

with reporting requirements of any states where an employer with whom the BCBSA Member Company contracts has employees, as many of these laws purport to have extra-territorial reach. Notably, Vermont's law does not require reporting only from third-party administrators or insurers stationed in Vermont, but from an entity – seemingly anywhere – that processes or insures benefits for a Vermont resident. *See* Vt. Stat. Ann., tit. 18, § 9410(b). The prospect is that a very large employer with employees in every state – or the third-party administrator or insurer with whom the employer contracts – must comply with fifty states' different APCD laws. And sometimes it must comply with two or more states' laws for the same data, such as when one state requires data about its residents' claims wherever incurred, and the state where the claims were incurred requires reporting on all claims in the state, irrespective of whether the recipient is a resident.

It is burdensome to respond to a single state's APCD law. In BCBSA Member Companies' experience, it is not uncommon that, once such a law has been enacted, a full-court press is required initially to create and bring "on line" the systems necessary for compliance. It can require the work of multiple full-time employees as well as hundreds of additional employee hours to wade through technical issues with the state's data vendor and through legal issues with state regulators. And once reporting begins, the compliance systems do not continue forward on autopilot; there is an ongoing burden to keep the data reporting system up and running. To comply with a single state law, this can require several full-time employees on an open-ended basis, as well as signifi-

cant financial outlays associated with support provided by outside vendors.[7]

One major, and time-consuming, complication often encountered is the seemingly arbitrary percentage-based "thresholds" set by state laws for how many claims files must contain a particular data element, in order for the files to avoid a finding of noncompliance. States can require, for instance, that third-party administrators and insurers report who recommended admission to a medical facility. If the healthcare provider does not include that information when submitting his or her claim to the ERISA plan administrator or insurer, then the entity doing the reporting will not have the data. If the state sets a minimum threshold requiring that at least 50% of all claim files submitted to the state by that entity must include that data, the entity might not meet the reporting threshold. And if it does not meet the threshold, the entity must devote additional time and resources to seeking variances from the

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[7] For example, Vermont specifies in detail the file format and other technical requirements necessary for data submission. *See* Vt. Reg. H-2008-01, §§ 6, 7. The technical systems, therefore, must be developed to allow for the reporting of the requested data. Before data can even be submitted, the reporter must submit a test file to ensure compliance. *See id.* § 6(E). Thereafter, if a data file does not conform, it must be corrected and resubmitted within ten days. *See id.* The same scenario can replicate itself in other states where the reporter must likewise report for data subject to that jurisdiction's APCD law. And the tasks are made even more complicated and time-consuming because the reporter must additionally scrub data to comply with overriding federal directives, such as the federal Substance and Alcohol Abuse statute. *See* 42 C.F.R. pt. 2.

state – for data that the healthcare provider simply never supplied.[8]

Further complications arise due to a lack of uniformity among the states as to the data they require, the format in which it must be reported, and the frequency with which it must be transmitted. Time and resources are required just to track which states have reporting laws and determine whether compliance is required, and then to implement and run the necessary programs. Over time, state reporting requirements also change, adding to the expense.

To be sure, BCBSA's Member Companies incur these burdens on a large scale because they are in the business of providing services and products (administrative or insurance-related) to ERISA plans and therefore deal with large swaths of information. But the burdens do not go away when moved from a macro to a micro scale. If anything, they become more acute. Again, Vermont's law applies, under implementing regulations to "any administrator of an insured, self-insured, or publicly funded health care benefit plan offered by public and private enti-

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[8] Another aspect of APCD laws that creates severe difficulties especially for out-of-state entities administering benefits for the reporting state's residents is that the reporting state often requires data on plan features otherwise mandated by the reporting state in its insurance role (*e.g.*, about cost-sharing or copay features, etc.). But the out-of-state entity, if a self-funded ERISA plan, will have created its own benefits array limited only by what federal law mandates; and insured ERISA plans would have followed their own state's benefit mandates. Thus, the state requiring reporting may want information on a topic foreign to the out-of-state entity doing the reporting on Vermont residents. When that box then shows up empty (or below the minimum threshold of anticipated data responses), the report would be rejected, spiraling the endeavor into an effort to explain, and get approval for, variances.

ties." Reg. H-2008-01, § 3(X). Accordingly, a large ERISA plan that is self-administered, and has participants and beneficiaries throughout the country, would face the same systems start-up and ongoing costs of compliance, except for a smaller universe of individuals. The economies of scale that a BCBSA Member Company might enjoy to make compliance more streamlined would be nonexistent in the single ERISA plan situation, with its burden then repeated by other single ERISA plans to the same degree.

CONCLUSION

The Court should affirm the decision of the Court of Appeals.

Respectfully submitted,

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